

DRAFT

PART I - FACESHEET

APPLICATION FOR FEDERAL ASSISTANCE

2. DATE SUBMITTED TO CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS):		3. a. DATE RECEIVED BY STATE:	1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Non-Construction <input checked="" type="checkbox"/>																										
		4. a. DATE RECEIVED BY CNS:	3.b. STATE APPLICATION IDENTIFIER: 4.b. CNS GRANT NUMBER:																										
5. APPLICANT INFORMATION																													
LEGAL NAME: ORGANIZATIONAL UNIT: ADDRESS (give street address, city, county, state and zip code):		NAME AND CONTACT INFORMATION FOR PROJECT DIRECTOR OR OTHER PERSON TO BE CONTACTED ON MATTERS INVOLVING THIS APPLICATION (give area codes): NAME: TELEPHONE NUMBER: () - FAX NUMBER: () - INTERNET E-MAIL ADDRESS:																											
6. EMPLOYER IDENTIFICATION NUMBER (EIN): <table border="1"><tr><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>					-							7.a. TYPE OF APPLICANT: (enter appropriate letter in box) <input type="checkbox"/> <table><tr><td>A. State</td><td>H. Independent School District</td></tr><tr><td>B. County</td><td>I. State Controlled Institution of Higher Learning</td></tr><tr><td>C. Municipal</td><td>J. Private University</td></tr><tr><td>D. Township</td><td>K. Indian Tribe</td></tr><tr><td>E. Interstate</td><td>L. Individual</td></tr><tr><td>F. Intermunicipal</td><td>M. Profit Organization</td></tr><tr><td>G. Special District</td><td>N. Private Non-Profit Organization</td></tr><tr><td colspan="2">O. Other (specify) _____</td></tr></table>		A. State	H. Independent School District	B. County	I. State Controlled Institution of Higher Learning	C. Municipal	J. Private University	D. Township	K. Indian Tribe	E. Interstate	L. Individual	F. Intermunicipal	M. Profit Organization	G. Special District	N. Private Non-Profit Organization	O. Other (specify) _____	
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8. TYPE OF APPLICATION (Check appropriate box): <input type="checkbox"/> NEW <input type="checkbox"/> CONTINUATION <input type="checkbox"/> REVISION If Revision, enter appropriate letter(s) in box(es): <input type="checkbox"/> <input type="checkbox"/> A. Increase Award: <input type="checkbox"/> B. Decrease Award: <input type="checkbox"/> C. Increase Duration: <input type="checkbox"/> D. Decrease Duration: <input type="checkbox"/> E. Other (specify below): <input type="checkbox"/> _____		7.b. CNS APPLICANT CHARACTERISTICS Enter appropriate code in each blank: _____, _____, _____, _____, _____																											
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Name of Program _____								9. NAME OF FEDERAL AGENCY: Corporation for National and Community Service																					
12. AREAS AFFECTED BY PROJECT (List Cities, Counties, States, etc.):		11. TITLE OF APPLICANT'S PROJECT:																											
13. PROPOSED PROJECT: START DATE: END DATE:																													
14. ESTIMATED FUNDING: Check applicable box: Yr 1: <input type="checkbox"/> Yr 2: <input type="checkbox"/> or Yr 3: <input type="checkbox"/>		15. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?																											
a. FEDERAL	\$	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE _____																											
b. APPLICANT	\$	b. NO. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372																											
c. STATE	\$	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW																											
d. LOCAL	\$	16. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?																											
e. OTHER	\$	<input type="checkbox"/> YES If "Yes," attach an explanation. <input type="checkbox"/> NO																											
f. TOTAL	\$	17. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.																											
a. TYPED NAME OF AUTHORIZED REPRESENTATIVE:		b. TITLE:	c. TELEPHONE NUMBER:																										
d. SIGNATURE OF AUTHORIZED REPRESENTATIVE:		e. DATE SIGNED:																											